ME Aesthetics
EST. 2022

Intravenous Therapy Consent Form

I, __________________________ DOB ___/___/___ , hereby authorize the following intravenous therapies (check all that apply):

❏ Recovery & Performance
❏ Immunity & Wellness
❏ Get up and Go
❏ Myers Cocktail
❏ Inner Beauty
❏ Alleviate
❏ Reboot
❏ Hearing Loss

I understand that these treatment(s) each have a specific formula containing some or all of the following: Ascorbic Acid (Vitamin C), Vitamin D, B vitamins, Magnesium Chloride, Calcium, Zinc, Minerals, Amino Acids, Trace Elements, and Glutathione, which are compounded in an FDA approved pharmacy and supplied by a third party, Olympia. I understand that this procedure is an intravenous supplementation, not replacement, of these essential nutrients listed above, and recommended but not guaranteed to:

- Maintain and enhance normal bodily functions
- Improve immune function
- Improve antioxidant status/Reduce oxidative damage through detoxification
- Improve fatigue - Increase energy - Improve athletic performance
- Improve proper hormone production
- Increase metabolism and assist with weight loss
- Optimize brain function/Increase mental focus
- Improve certain cardiovascular ailments
- Reduce histamine release improving allergy symptoms
- Improve gastrointestinal disorders
- Promote healing from injury/surgery/intense exercise or training - Improve signs of aging
-Assist with symptom management (headaches, muscle cramps, gastrointestinal discomfort, pain)

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Please initial next to each:

______ The procedure involves inserting a needle into a vein, placing a soft catheter, and infusing the elected therapy by a medical professional acting within their active state-regulated license/guidelines under the direct supervision of a physician.

______ Benefits of intravenous therapy include but not limited to:

❖ All of the above listed benefits related to my specific treatment.

❖ Absorption of these supplements and hydration is optimized as they bypass your gastrointestinal system, allowing for higher doses via direct delivery to all cells by means of a high concentration gradient.

❖ Decrease gastrointestinal discomfort associated with orally ingesting high doses of supplements.

❖ Increased safety as these supplements are water-soluble, meaning whatever your body does not utilize is excreted by your kidneys.

______ Alternatives to intravenous therapy are oral vitamins, capsules, liquid drinks, lotions, topical creams, mouth sprays, dietary and lifestyle changes.

______ There are risks and side effects, although uncommon, to receiving intravenous therapy even when administered properly. While most side effects are extremely rare, there are some that may be experienced more commonly. This can vary person to person due to current health and history, some of these side effects can include but are not limited to:

● Discomfort, burning/stinging sensation, and/or pain at the site of injection
● Sense or feeling of being swollen over the entire body (bloating)
● Changes in appearance of skin and tissue at or around the insertion site (bruising)
● Inflammation of the vein used for injection/phlebitis
● Misplacement of the IV during insertion/infiltration
● Bleeding at the insertion site
● Scarring/injury at the insertion site, including but not limited to vein, nerve injury and tissue necrosis
● Gastrointestinal upset: nausea, vomiting, diarrhea, constipation, indigestions, heartburn
● Metabolic disturbances
● Headache
●

● Infection, chills, fever
● Cardiovascular disturbances: rapid heart rate, palpitations, chest pain, flushed face, vagal response
● Cardiac arrest, air embolism and death
Muscle spasms, weakness, fatigue, dizziness
● Allergic reactions (itching, hives, rash, swelling, difficulty breathing, wheezing, anaphylaxis)

______ I assume responsibility to notify and/or seek immediate medical attention if any of the above side effects occur and are severe or are troublesome for medical evaluation.
______ I have, to the best of knowledge, in written form notified my medical provider(s) of known allergies, current medications/supplements, all past and current medical conditions/diseases/disorders, as well as any other pertinent personal/health/social/lifestyle information in order to minimize complications.
______ I understand that certain medications/supplements whether natural, over-the-counter or prescribed, as well as known or unknown medical conditions, may increase my risk of the above side effects/risks.
______ I am aware that other unforeseeable complications can occur. I do not expect the medical provider(s) to anticipate and/or explain all risks and possible complications. I rely on the medical provider(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the procedure, the treatment, the risks and benefits of the procedure, have had the opportunity to have all of my questions answered, and have the right to refuse/stop treatment at any time.
______ I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure.
______ I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications, therefore may be considered medically unnecessary or not currently indicated.
______ I hereby acknowledge that I understand that this procedure is not covered by my insurance. I agree to be personally and legally responsible for payment at the time of service for all services, including non-covered services.
______ I further agree in the event of nonpayment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.
______ I understand my personal information will be kept private and protected in compliance with HIPAA and have signed a Notice of Privacy agreement with Premier Plastic Surgery Center and Spa.
______ I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks, known and unknown. I hereby give consent to Broward ENT and Aesthetics to perform this and all subsequent Intravenous Therapies with the above understood. I hereby release the Medical Director, the medical provider performing the Intravenous Vitamin delivery, Broward ENT and Aesthetics, as well as the third-party supplier Olympia from all liability.

Patient: ____ Date: ____________________

I have discussed the above with the patient and have answered their questions.

Provider: ______________________________________ Date: ____________________

MARIA ESPINEL EST. 2022 AESTHETIC LOUNGE